ELIGIBILITY & ENROLLMENT UNIT (EEU)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

APRIL 2014

INTRODUCTION

We recognize that the workload in the local agencies is at an all time high right now due to the transition to VaCMS. The EEU of DMAS is here to assist with issues and to provide technical guidance wherever possible. If you have suggestions for how the EEU could help to alleviate the workload or to improve efficiency please email us. We check the Enrollment and Patient Pay Inboxes regularly and welcome your questions or concerns.

HOSPICE

The ABD Hospice covered group is for individuals who have a Hospice election in place for 30 days or more and are not eligible in any other full-benefit Medicaid covered group. If the individual is eligible in another Medicaid full-benefit covered group then hospice care will be a covered service. The individual should be enrolled in the full-benefit covered group in which they are eligible and only evaluated in the ABD Hospice covered group if they do not meet any other covered group.

Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to eligibility renewal every 12 months. At the time of the annual renewal the worker must verify that the hospice agreement is still in effect.

Additional information regarding the ABD Hospice covered group can be found in chapter M0320.503 of the Medicaid Eligibility Manual.

Did You Know?

That members who meet a medically needy spenddown must have eligibility entered into the MMIS as a closed period of coverage? Any spenddown that has dates which overlap with an existing limited coverage line of eligibility must be sent to the EEU Enrollment Inbox for entry by DMAS staff.

DMAS Contact Information

Eligibility & Enrollment Inbox:
enrollment@dmas.virginia.gov

Patient Pay Inbox:
patientpay@dmas.virginia.gov

Buy-In Inbox
buyin@dmas.virginia.gov

HIPP Inbox
hipp@dmas.virginia.gov

Additional DMAS contact information can be found in Chapter A of the MMIS User's Guide located on the EEU Webpage at: http://dmasva.dmas.virginia.gov/content_pgs/dss-elgb_enrl.aspx

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE) - CORRECTION

There is a correction to information that was presented in the February 2014 WebEx section as well as information contained in Transmittal #99. Individuals who are enrolled on the basis of HPE receive a closed period of coverage from the date the hospital staff approves the coverage through the end of the following month. This is a change from the previous instruction that HPE coverage would begin on the first of the application month.

Example: An HPE application is processed and approved by hospital staff on March 15th. The individual will be enrolled in the appropriate HPE covered group from March 15th (the date the application was approved) through April 30th (the end of the following month).

Section M0120.500 of the Medicaid Eligibility Manual has been revised in Medicaid Update #10 and contains the correction above, as well as additional information about HPE and examples to help guide eligibility workers with handling Medical Assistance applications submitted by HPE enrollees.

MMIS TIP – EMERGENCY SERVICES

All members who are found eligible for Emergency Services Medicaid must have an "A" in the Citizenship Status of the Member Demographic screen. When the closed period of eligibility is entered, a cancel reason of "020" will automatically populate which indicates that the line of eligibility is Emergency Services. Additionally, on the Benefits Screen the line "XIX FFS EME" should be present, which is the Emergency Services benefit plan. If this code is not present, do not select update, return to the Member Demographic screen and review to ensure that the correct data is present. Issues with Emergency Services enrollments should be directed to the Enrollment Inbox at enrollment@dmas.virginia.gov.

PATIENT PAY - STAYS LESS THAN 30 DAYS

When determining the patient pay for a non-institutionalized individual who has full-Medicaid coverage and is admitted to a facility for less than 30 days, the procedures in Chapter M1470.310 B.1 of the Medicaid Eligibility Manual should be used.

A non-institutionalized individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If the spenddown is met within the dates of facility service, take the following steps to determine patient pay:

- Add together the number of days in the facility that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.
- Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.
- Add the amount from step one to the amount in step two. This total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

This procedure can be found in Chapter M1470.320 B.1 of the Medicaid Eligibility Manual.

COMMONWEALTH COORDINATED CARE (CCC)

On February 28, 2014, approximately 37,000 letters were mailed to dual eligible recipients in the Central Virginia and Tidewater regions announcing the roll-out of the CCC Program. CCC is a demonstration program for enrollees over age 21 who live in the pilot areas and who have full Medicaid and Medicare benefits. It is operated under a three-way contract between CMS, DMAS, and the health plans (managed care organizations referred to as MMP's, which stands for Medicaid-Medicare Plans). The three contracted MMP's are Humana, Virginia Premier, and Anthem HealthKeepers. CCC enrollees choose one of the three health plans and the health plan provides ALL Medicare and Medicaid-covered services, in addition to some enhanced benefits which vary by plan. One of the most significant aspects of the CCC program is the assignment of a care coordinator for each enrollee. The CCC program is also available to Medicaid individuals in nursing facilities and those enrolled in the Elderly and Disabled Waiver with Consumer Direction (EDCD) waiver.

The CCC program is voluntary: recipients can opt in, opt out, or change health plans at any time. All enrollments for the program are done by the enrollment broker, Maximus. Enrollees can contact the enrollment broker at (855) 889-5243 M-F from 8:30-6:00 to opt-in, opt-out, or ask questions about the CCC program. In addition, DMAS continues to conduct outreach and education meetings, weekly provider and recipient calls, and town hall meetings to reach providers, enrollees and their advocates regarding the program and respond to questions. Information about forthcoming events can be found on the DMAS website under Commonwealth Coordinated Care, or questions can be submitted to the CCC mailbox at: CCC@dmas.virginia.gov.

In order to ensure that potentially eligible recipients receive information about the CCC program, or that the MMP's can reach out to individuals once they are enrolled, it is important that DSS update the address, TPL, and any authorized representative information (comments screen) in the MMIS, as appropriate.

Mark your calendar! The next MMIS WebEx training sessions will be held on June 11, 2014 and June 18, 2014. An agenda along with registration links will be released in May by broadcast and on the announcement section of the MMIS Portal. Submit any training requests or ideas to the MMIS WebEx Inbox at mmiswebex@dmas.virginia.gov.